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Department of Health & Human Services (DHHS)

MaineCare

Medicaid Management Information Systems

Maine Integrated Health Management Solution

CMS 1500 Billing Instructions Guide

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1. Introduction

This document provides billing instructions for professional services provided to MaineCare members when submitting paper claims for processing in the Maine Integrated Health Management Solution (MIHMS). As alternatives to paper, providers are encouraged to submit claims using the HIPAA compliant EDI 837P format or by Direct Data Entry (DDE), which is an online process where data is directly entered into MIHMS for processing and payment. These paperless alternatives provide countless efficiencies for claims processing without the traditional problems associated with the submission of paper claims such as getting lost in the mail, data entry errors, delayed adjudication, etc. Providers electing to use DDE or EDI must register as a Trading Partner after successful enrollment in MaineCare.

The CMS 1500 form, previously known as the HCFA 1500 form, is a billing form maintained by the National Uniform Claims Committee (NUCC). Each payer, including MaineCare, has different requirements for completing specific parts of the claim form.

Providers are encouraged to use these paper alternatives and may reach out for support by calling customer support at 1-866-690-5585.

- Direct Data Entry is an option for MaineCare providers that will work well for providers who would like to submit Claims, Authorizations, and Referrals directly into MIHMS. These functions can be done one at a time or set up using rosters to make the entry easier.
- Providers may also submit batch transaction files in the HIPAA compliant X12 EDI format.
- Additional information can be found for these billing options at the MIHMS website at: <https://mainecare.maine.gov/>.

The instructions contained in this document are to be followed for completing the claim form for the submitted dates of service to include September 1, 2010 forward. Service dates prior to September 1, 2010 will not be processed by MIHMS, but will follow different billing instructions as specified in the MECMS billing requirements. Providers who need assistance with billing MECMS claims contact your State Provider Relations Specialist at 1-800-321-5557.

Each provider is responsible for obtaining their own CMS 1500 forms; the Maine Department of Health and Human Services (DHHS) does not provide them.

CMS 1500 forms are red printing on white paper. You can buy the forms at office supply centers or from other sources including:

U.S. Government Printing Office
Mail Stop: IDCC
732 N. Capitol St. NW
Washington, DC 20401
<http://www.gpo.gov/>

General Guidance on Submitting Claims

Claim types by MIHMS Provider Types are listed in the following table:

Table 1: MIHMS Provider Types

MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Adult Day Health	19, 26	No	√	
Advanced Practice Registered Nurse Group	14, 96	Yes	√	

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MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Advanced Practice Registered Nurse	13, 14, 96	No	√	
Alternative Residential Facility	2	No		√
Ambulance Note: Hospital owned Ambulance services should be billed on the UB form.	5, 113	No	√	
Ambulatory Surgical Center	4	No	√	
Assisted Living Service Provider	96	No	√	
Audiology (Group)	35, 109	Yes	√	
Audiologist	35, 109	No	√	
Behavioral Health Clinicians Group	65	Yes	√	
Behavioral Health Clinician Note: The BHC with SP 167 BCBA will attest to 21/28/107	13, 65, 21, 28,107	No	√	
Boarding Home	97	No		√
Case Management	12,13, 19, & 96	No	√	
Children's Community Rehabilitation	28	No	√	
Chiropractic Group	15	Yes	√	
Chiropractor	15	No	√	
Community Provider/ FQHC, RHC, IHS	31, 103, 9	No		√
Dialysis Center - Free Standing	7	No		√
DME Supplier	35, 60	No	√	
Early Childhood	28	No	√	
Family Planning Agency	30	Yes	√	
Fiscal Employer Agent	12, 19, & 96	No	√	
Group Home - IID	50	No		√
Government Agency	13			
Home Health Agency	19, 40 & 96	No		√
Hospice	43	No		√
Hospital (see notes below) / Hospital, Critical Access	45	No		√

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MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Note: Hospitals are required to split bill their professional services to a CMS1500 in a manner that mirrors their Medicare billing.	various	Yes	√	
Indian Health Services Provider Note: IHS providers enrolling as a Community Provider must follow guidelines for that Provider Type.	9	Yes	√	
Intermediate Education Unit	28,	No	√	
	68, 85 & 109	Yes	√	
Interpreter Services for Dental Providers Note: Providers billing for interpreter services need to put the healthcare provider's rendering id on the claims.	25	Yes	√	
Laboratory/Radiology	55, 62 & 101	No	√	
Medical Food Supplier	60	No	√	
Mental Health Clinic / Behavioral Health Services, Community Support Services	17, 23, 65	Yes	√	
Developmental and Behavioral Health Clinic		No	√	
Mental Health Clinic - ACT		No	√	
Mental Health Clinic – Intensive Case Management		No	√	
Nurse	13, 19, 96	No	√	
Nursing Home	19, 26, 50, 67 & 97	No		√
Occupational/Physical Therapy Group	19, 68 & 85	Yes	√	
Occupational Therapist	19 & 68	No	√	
Physical Therapist	19 & 85	No	√	
Psychiatric Residential Treatment Facility	107	No		√
Optician	35, 75	No	√	
Optometrist	75	No	√	
Pharmacy	35, 80	No	None	
Physicians Group	90	Yes	√	
Physician	90	No	√	

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MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
PNMI - Private Non-Medical Institution	97	No		√
Podiatry Group	95	Yes	√	
Podiatrist	95	No	√	
PCA Agency	19, 96	No	√	
Psychiatric Hospital	46	No		√
Note: Psychiatric Hospitals are required to bill their professional services in a manner that mirrors their Medicare billing	various	Yes	√	
Public School	28, 65 & 96	No	√	
	68, 85 & 109	Yes	√	
Rehabilitation Center	102	No	√	
School Health Center	3	Yes	√	
Special Purpose Private School	28, 65, 68, 85, 96 & 109	No	√	
Speech Language Pathology Group	19, 109	Yes	√	
Speech Language Pathologist	19, 109	No	√	
Speech/Hearing Therapist Group	35, 109	Yes	√	
State Agency	13, 17, 21, 65	No	√	
State Agency / Dentist Public Health	25	Yes	√	
State Psychiatric Hospital	46	No		√
Substance Abuse Provider	13, 65	Yes	√	
Transportation	113	No	√	
Vision Center	75	No	√	
Vision Services Provider Group	35, 75	Yes	√	
Waiver Services Provider	19, 20, 21, , 29, & 32	No	√	
Dental Group	25	Yes	ADA 2012	
Dental Hygienist Group		Yes	ADA 2012	
Denturist Group	25	Yes	ADA 2012	

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MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Dental Hygienist, Dentist, Denturist,		No	ADA 2012	
Note: Oral Surgeons who provide services outside of Section 25 may bill MaineCare for those services using the CMS1500			√	

1. Billing instructions are intended to assist providers with the preparation of claims, and are intended to supplement the guidance provided in the applicable MaineCare Policy. Policies may be accessed at the following website: <http://www.maine.gov/sos/cec/rules/10/ch101.htm>
2. Paper claims will be returned to the provider for any of the following reasons:
 - a. Not on an original Claim Form.
 - b. The form/attachment is incorrect, not legible, print is too light, and/or the alignment is not correct (1 character out of alignment or more).
 - c. Claim is damaged.
 - d. The form includes the use of any correction tape or liquid correction fluid or crossed out data.
 - e. Claim is completed with red ink.
 - f. Attachment is completed with red ink.
 - g. An attachment:
 - h. Is not 8 ½ x 11
 - i. Has double sided content
 - j. Federal Tax ID is less than 9 digits.
 - k. Patient's First and/or Last name are missing.
 - l. Patient's Date of Birth is missing or not in MMDDCCYY format.
 - m. Claim does not have at least one line of detail in lines 24 with data in A and D.
 - n. Signature (typed or stamped is acceptable) and/or date is missing.
 - o. NPI is less than 10 digits or API is less than 10 characters (A followed by 9 digits).
 - p. If Insured's ID # is not in one of these four valid formats:
 - i. Eight digits followed by A
 - ii. Eight digits followed by T
 - iii. Six digits preceded by T, or
 - iv. Six digits followed by T

NOTE: Additionally, paper claims are translated to an EDI X12 transaction and will be returned for any HIPAA validation errors. Providers will receive a letter indicating the claim is being returned for HIPAA.

3. Codes
 - a. Use Current Procedural Terminology (CPT) of the American Medical Association, ICD (International Classification of Diseases) Diagnostic Codes, or Healthcare Common Procedure Coding System (HCPCS) Codes maintained by the Centers for Medicare and Medicaid Services, or,
 - b. Use the Procedure Codes in the applicable Chapter III of the MaineCare Benefits Manual policy section. Access to these codes can be found at the following website: <http://www.maine.gov/sos/cec/rules/10/ch101.htm>
 - c. The following codes are not listed in each section of policy, but must be used when billing interpreter services:
 - i. T1013 Sign language or oral interpreter services per fifteen minutes.

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- ii. T1013-GT Interpreter Services provided via documented use of Pacific Interpreters, Language Line, or equivalent telephone interpreting service must be by report with copies of the invoice attached.
- 4. Special Instructions
 - a. Some providers who use the CMS 1500 form need to follow special instructions for certain fields. Special instructions are listed for each field.
- 5. Dates
 - a. The required format for most dates is eight digits (MMDDCCYY).
 - i. Example: January 19, 1947= 01191947
 - b. The date format for service may be either six (6) digits (MMDDYY) or eight (8) digits (MMDDCCYY).
 - i. Example: January 19, 1947= 011947
- 6. Multi-paged claim
 - a. Page Total: Do not put the total claim amount on any first or intermediate page.
 - i. The total must be placed on the last or final page of the multiple-paged claim. If the total is placed on each page, MaineCare will consider the page a stand-alone claim.
 - b. Fill out header information on each page with identical information. This will help ensure that the claim pages are kept together.
 - c. Other than Service Lines and Totals, only header information from page 1 will be used for actually processing the claim.
 - i. Attachments (e.g., operative notes) for a multiple-page claim will be placed after the last page of the claim, and the attachment(s) will be secured with a paperclip.
 - d. Put page numbering for multi-page claims (in the format *page of total pages*) in the open area in the upper right hand area of the claim form.
- 7. Mailing Claims
 - a. Send the Claim Form, including replacement or reversal claims, to:
MaineCare Claims Processing
M-500
Augusta, ME 04332-0011
- 8. Attachments and Attachment Uploads
 - a. Attachments may be provided in any of the following ways:
 - i. Attach paper attachment to a paper claim.
 - ii. Attachments may be uploaded through the Portal when submitting claims via Direct Data Entry.
 - iii. Attachments may be uploaded through the Portal for previously submitted claims by searching for the matching claim in Claims Status and uploading a scanned attachment directly to the claim.
 - 1. Acceptable file formats for upload are: PDF, GIF, JPEG/JPG, TIFF, MS Word, and MS Excel.
 - 2. Attachments must be submitted on the same day. If appropriate attachment is not present when the claim is being reviewed, it will deny.
 - 3. For detailed instructions regarding uploading attachments through the Portal, refer to the appropriate MHP User Guide at the following link:
<https://mainecare.maine.gov/MyHealth%20PAS%20User%20Guides/Forms/Publication%20View.aspx>.
 - b. When submitting claims after Medicare C Plans, write “Medicare” on the Explanation of Benefits.

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- c. Spend down letters should be attached for each claim where the member has a coverage code of “Spend Down” for that particular date of service.
 - d. Abortion form should be submitted along with the claim. This service is not prior authorized. Submit the required documentation along with the claim form after the service is performed. The form is signed by the physician and attests to certain conditions.
- 9. Billing for Non-Covered Medicare Services
 - a. Occasionally, there are services for which MaineCare pays, when Medicare does not cover them. For claims to process appropriately, the claim that is submitted to MaineCare must be billed in the same manner as it is when billing MaineCare as the primary payer.
 - i. Non-hospital providers:
 - 1. UB04: FL50, line “A” must reflect the word “MaineCare”, FL58 and FL60 must reflect the member’s name and MaineCare ID respectively.
 - 2. UB04 and CMS1500: Attach the Explanation of Medicare Benefits (EOMB), and at the top of the EOMB write “non-covered charges”. **Do not write on the claim, only on the EOMB.**
 - b. If submitting a claim that includes both covered and non-covered services previously billed to Medicare, the covered and non-covered services must be billed to MaineCare on separate claims. Appendix A: includes a summary for Third Party Billing.
- 10. Field Usage
 - a. These instructions include description of whether each Box is Required, Situational, Optional, or Not Used, according to these definitions:
 - i. Required– This item must be completed with the proper information as specified.
 - ii. Situational– This item must be completed with the proper information, if the stated triggering event applies.
 - iii. Optional– This item can be completed at your discretion (for example, to avoid having to file claims differently for MaineCare), but if used, must contain the information as specified by the AMA guidelines, or as superseded by these instructions, if they differ.
 - iv. Not Used– This item need not be completed as MaineCare/MIHMS never looks at this field.

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2. CMS 1500 Claim Form

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
<div> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> PICA </div> </div>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA-BULKING <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (DADCode) (Member ID) (ID#) (ID#) (ID#)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F					
4. INSURED'S NAME (Last Name, First Name, Middle Initial)						5. INSURED'S ADDRESS (No., Street)					
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)					
8. RESERVED FOR NUCC USE						8. RESERVED FOR NUCC USE					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL _____						15. OTHER DATE QUAL _____ MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____ 17b. NPI _____					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____											
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											
22. SUBMISSION CODE _____ ORIGINAL REF. NO. _____											
23. PRIOR AUTHORIZATION NUMBER _____											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS POINTER E. F. CHARGES G. DAYS OR UNITS H. RATE PER PW I. ID. QUAL J. RENDERING PROVIDER ID. #											
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ NPI _____ NPI _____ NPI _____ NPI _____ NPI _____ NPI _____											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gen. charges use back) <input type="checkbox"/> YES <input type="checkbox"/> NO					
28. TOTAL CHARGE \$ _____						29. AMOUNT PAID \$ _____					
30. Reserved for NUCC Use						31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					
32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # ()					
SIGNED _____ DATE _____						SIGNED _____ DATE _____					

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 2-1: CMS 1500 Form

3. Form Instructions

The form instructions will describe how each field should be filled out using either Required, Situational, or Not Required.

3.1 BOXES 1 through 1a

Figure 3-1: Boxes 1 through 1a

Box 1: Carrier Information

- Not Labeled on the CMS1500
- Required
 - Enter an X in the Medicaid box for a MaineCare claim.

Box 1a: Insured's I.D. Number

- Required
 - Enter the members' MaineCare Identification number.
 - To verify a member's MaineCare eligibility:
 - Use MyHealth PAS online portal; or
 - Submit a 270 EDI Request for Eligibility verification request, or
 - Use the Interactive Voice Response system (IVR)

3.2 BOXES 2 through 8:

Figure 3-2: Boxes 2 through 8

Box 2: Patient's Name

- Required
 - Enter the member's name exactly as it appears on his/her MaineCare eligibility card: last name, first name, and middle initial.

Box 3: Patient's Birth Date and Sex

- Required
 - Enter member's date of birth.
 - Must be in MMDDCCYY format, e.g., 10122009.
 - Enter an X in the appropriate M or F checkbox.

Box 4: Insured's Name

- Not Used

Box 5: Patient's Address

- Required
 - Enter the address of the MaineCare member

Box 6: Patient's Relationship to Insured

- Not Used

Box 7: Insured's Address

- Not Used

Box 8: Reserved for NUCC Use

- Not Used

3.3 BOXES 9 through 9d

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR
c. RESERVED FOR
d. INSURANCE PLAN NAME OR PROGRAM NAME

9d: the payer names must be spelled out (ie: Anthem Blue Cross)

Figure 3-3: Boxes 9 through 9d

Box 9: Other Insured's Name

- Situational (If the MaineCare member is covered by other primary insurance, and required if “Yes” is checked in Box 11d.)
 - If the member is covered by a primary insurance, submit the claim to other insurers prior to submitting the claim to MaineCare.
 - Attach a copy of the Explanation of Benefits or Remittance Statement from the primary insurance.
 - Enter the name of the policyholder.
 - Do not enter Medicare Part A/B or any other State program information.
 - If this box is completed, also complete Boxes 9a and 9d.
 - If there is no other insurance, leave this box and all fields (9–9d) blank.

Box 9a: Other Insured's Policy or Group Number

- Situational (Required if “Yes” is checked in Box 11d.)
 - Enter the policy or group number of the primary insurance.

Box 9b: Reserved for NUCC Use

- Not used

Box 9c: Reserved for NUCC Use

- Not Used.

Box 9d: Insurance Plan Name or Program Name

- Situational (Required if a person is listed in Box 9, and required if “Yes” is checked in Box 11d)
 - Enter the name of the primary insurance plan or program name. (Example: Anthem Blue Cross Plan B).
 - When billing for Medicare C (Medicare Advantage Plans), the payer name must be spelled out as “Medicare”.

3.4 BOXES 10 through 10d

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. AUTO ACCIDENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLACE (State) <input type="text"/>	
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
10d. CLAIM CODES (Designated by NUCC)	

Figure 3-4: Boxes 10 through 10d

Box 10: Is Patient's Condition Related To:

- Situational
 - Check appropriate box if the treatment is related to employment, an auto accident or other accident.

Box 10a: Employment? (Current or Previous)

- Situational
 - Check appropriate box if the treatment is related to current or previous employment.

Box 10b: Auto Accident? (Enter State)

- Situational
 - Check appropriate box if the treatment is related to an auto accident.
 - Indicate the two letter State abbreviation for the State where the accident occurred.

Box 10c: Other Accident?

- Situational
 - Check appropriate box if the treatment is related to other accident.

Box 10d: Claim Codes (Designated by NUCC)

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- Situational
 - Use the appropriate claim code to identify additional information about the patient's condition or the claim. Applicable claim codes are designated by the NUCC.
 - When reporting more than one code, enter three blank spaces and then the next code.
 - **FOR WORKERS COMPENSATION CLAIMS:** Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these conditions). **Note:** Do not use Condition Codes when submitting a revised or corrected bill.

Table 2: Condition Codes for CMS 1500

Code	Description
AA	Abortion performed due to Rape
AB	Abortion performed due to Incest
AC	Abortion Performed due to Serious fetal genetic defect, deformity, or abnormality
AD	Abortion performed due to a life endangering physical condition caused by, arising from or exacerbated by the pregnancy itself
AE	Abortion performed due to physical health of mother that is not life endangering
AF	Abortion performed due to emotional/psychological health of the mother
AG	Abortion performed due to social or economic reasons
AH	Elective abortion
AI	Sterilization
Worker's Compensation Claim Codes	
W2	Duplicate of original bill
W3	Level 1 appeal
W4	Level 2 appeal
W5	Level 3 appeal

3.5 BOXES 11 through 11d

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	

Figure 3-5: Boxes 11 through 11d

Box 11: Insured's Policy Group or FECA Number

- Situational
 - Complete if "Y" is checked in Box 11d.

Box 11a: Insured's Date of Birth and Sex

- Not Used

Box 11b: Other Claim ID

- Not Used

Box 11c: Insurance Plan Name or Program Name

- Not Used

Box 11d: Is There Another Health Benefit Plan?

- Required
 - If the MaineCare member is covered by other primary insurance even if the member is not the policyholder, enter an X in the YES box and also complete Fields 9, 9a, and 9d.
 - Enter an X in the "No" box if the member has Medicare, Medicare C, or is covered by any other State program
 - If there is no other insurance, enter an X in the NO box

3.6 BOXES 12 through 13

Box 12: Patient's Or Authorized Person's Signature

- Not Used

Box 13: Insured's or Authorized Person's Signature

- Not Used

3.7 BOXES 14 through 16

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
--	---------------------------------	---

Figure 3-6: Boxes 14 through 16

Box 14: Date of Current Illness, Injury or Pregnancy (LMP)

- Situational (Required if 10 a, b, or c are checked as Yes and/or if pregnant).
 - Enter the applicable date.
 - Can be either MMDDYY or the MMDDCCYY format.
 - For pregnancy, use the date of the last menstrual period (LMP) as the first date
- Enter the applicable qualifier to identify which date is being reported. Enter the qualifier to the right of the vertical dotted line.
 - 431: Onset of Current Symptoms or illness
 - 484: Last Menstrual Period

Box 15: Other Date and Qualifier

- Situational, (Required if 10 a, b, or c are checked as Yes and/or if pregnant).

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- Enter another date related to the patient's condition or treatment. Can be either MMDDYY or MMDDCCYY format.
- Enter the applicable qualifier to identify which date is being reported. Enter the qualifier between the left-hand set of vertical dotted lines.

Table 3: Qualifiers

Qualifier	Description
454	Initial Treatment
304	Latest Visit or Consultation
453	Acute Manifestation of a Chronic Condition
439	Accident
455	Last X-Ray
471	Prescription
090	Report Start (Assumed Care Date)
091	Report End (Relinquished Care Date)
444	First Visit or Consultation

Box 16: Dates Patient Unable to Work in Current Occupation

- Not Used

3.8 BOXES 17 through 20

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">17a. NAME</div> <div style="width: 20%;">17b. NPI</div> </div> </div>	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FROM MM DD YY </div> <div style="width: 45%;"> TO MM DD YY </div> </div>
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div>

Figure 3-7: Boxes 17 through 20

Box 17: Name of Referring Physician or Other Source

- Situational (Required if member is part of Primary Care Case Management (PCCM) Program).
 - Referral Name is required if the member is enrolled in MaineCare PCCM and the specialty service requires a referral from the Primary Care Provider (PCP) site.
- Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. Do not use periods or commas. A hyphen can be used for hyphenated names.
 - If multiple providers are involved, enter one provider using the following priority order:
 1. Referring Provider
 2. Ordering Provider
 3. Supervising Provider
- The name of the Referring or Ordering provider is required on claims billed by DME, Lab, and Radiology providers.
- Enter the applicable qualifier to identify which provider is being reported. Enter the qualifier to the left of the vertical dotted line.

Table 4: Provider Qualifiers

Qualifier	Description
DN	Referring Provider
DK	Ordering Provider

Qualifier	Description
DQ	Supervising Provider

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jane A Smith MD
--

Figure 3-8: Provider Qualifier Example

Box 17a: Other ID#

- Situational
 - Required if Box 17B is left blank.
- The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code.
- Enter the applicable qualifier to indicate the type of number reported in 17a. The qualifier is reported to the immediate right of 17a.
- For DME, Lab, and Radiology providers; enter the applicable NPI of the physician or professional who ordered or referred services.

Table 5: Other ID Qualifier

Qualifier	Description
0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (used with Supervising Provider only)

Box 17b: NPI

- Situational: Required if 17 is completed.
 - Enter PCP's 10 digit NPI number.

Box 18: Hospitalization Dates Related to Current Services

- Not Used

Box 19: Additional Claim Information (Designated by NUCC)

- Not Used

Box 20: Outside Lab?

- Not Used

3.9 BOXES 21 through 23

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. _____	B. _____	C. _____	D. _____			
E. _____	F. _____	G. _____	H. _____			
I. _____	J. _____	K. _____	L. _____		23. PRIOR AUTHORIZATION NUMBER	

Figure 3-9: Boxes 21 through 23

Box 21: Diagnosis or Nature of Illness or Injury

- Required

- Enter the Applicable ICD indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.
 - 9: ICD-9-CM
 - 0: ICD-10-CM
- Enter the numeric International Classification of Diseases (ICD) code.
 - Use the code that is as specific as possible, according to ICD coding guidelines.
 - Do not enter the description of the diagnosis code.
 - Decimal points are required. If there is more than one diagnosis, enter each diagnosis code separately.
 - Enter no more than 12 diagnoses.
 - Enter the diagnosis codes most relevant to the procedure being billed.
 - Relate lines A-L to the lines of service in 24E by the letter of the line.
 - Ambulance claims must include a diagnosis code. For dates of service prior to 10/01/2015, use 780.99 (Other General Symptoms). For dates of service of 10/01/2015 and forward, use the appropriate ICD-10 code: R45.84 (anhedonia) or R68.89 (other general symptoms and signs).

Box 22: Resubmission Code/Original Ref. No.

- Situational (Required for Reversals and Replacements).
 - If this is a correction to a previously processed claim, in the Medicaid Resubmission Code Box, enter one of the following:
 - 7– for **Replacement** of a previous claim.
 - 8– for **Reversal** or Void.
 - In the Original Ref. No. Box, enter the previous Claim ID. Adjustments must be done at the claim level.

Box 23: Prior Authorization Number

- Situational (Required for services where multiple Prior Authorizations (PA) exist for the same date, service, member, and provider). See special billing instructions for populating PA numbers on claims ([Prior Authorization Numbers and Claim Submissions.](#))
 - Enter the PA number issued by the authorizing unit for the services or supplies being billed on this form.
 - Bill only one PA number on each claim form.
 - All services billed on the claim should be included in the PA.
 - A PA number submitted on the claim form must exactly match the authorization number in MIHMS including both alpha and numeric characters. (e.g. APS1234567890 or EIS0000000-011)

3.10 BOX 24: Service A - J

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
	From MM	DD	YY	To MM	DD	YY			(Explain Unusual Circumstances)	MODIFIER						
1																
2																
3																
4																
5																
6																

Figure 3-10: Box 24, Service A- J

Repeat Boxes 24 A through J for any additional services/procedures rendered. Multi paged claims are acceptable.

- At least one line is required.
 - For each line item billed, include one date, one place of service, one procedure code, and one amount charged per line.
 - See Appendix A for a summary of Third Party Billing Instructions.
 - The shaded area on each line is for supplemental information.
 - It is not intended to allow the billing of 12 service lines.

Box 24A: Dates of Service

- Required
 - If the service was provided on only one day, enter that date in the From Box and leave the To Box blank.
 - From and To dates on each line must be consecutive and continuous. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G (units need to be equal to or greater than the number of days).
 - On each line, the From and To dates must be during a single calendar month.
 - Use the next line for any dates of service occurring in the next calendar month.
 - Can be either MMDDYY or the MMDDCCYY format.

NOTE: For most claims, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code, with the following exceptions:

- Claims with services prior to and on or after 10/01/2015 can be billed on the same claim form if the claim is a DMEPOS claim. If the DMEPOS claim has a from date prior to 10/01/2015 and a through date on or after 10/01/2015, the entire claim is billed using ICD-9-CM codes based on the from date of service.
- Claims with anesthesia procedures that begin on 09/30/2015, but end on 10/01/2015, are to be billed with ICD-9 diagnosis codes and use 09/30/2015 as both the FROM and THROUGH date.

Box 24B: Place of Service

- Required
 - Enter the appropriate two-digit place of service code(s) from the list provided.
 - Identify the location, using a place of service code, for each item used or service performed.
 - **Durable Medical Equipment and Supplies Providers:** Use the Place of Service code where the member resides.

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- **Providers submitting Electronic Visit Verification (EVV) services:** Place of Service 10 is an unassigned code and should only be used in the following situations:
 - Section 28 services when the service is NOT delivered one-to-one within the member's home or when the service does not include personal care components.
 - Sections 12, 18, 19, 21, 29, 96 services when the individual providing the service is a live-in caregiver.

Table 6: Place of Service Code List

Place of Service Code List:	
01 Pharmacy	03 School
04 Homeless Shelter	05 Indian Health Service Free-standing Facility
06 Indian Health Service Provider-based Facility	07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider Based Facility	10 Unassigned
11 Office	12 Home
13 Assisted Living Facility	14 Group Home
15 Mobile Unit	17 Walk-in Retail Health Clinic
20 Urgent Care Facility	21 Inpatient Hospital
22 Outpatient Hospital	Should be used when a provider qualifies as a "Provider Based" entity under 42CFR413.65.
23 Emergency Room – Hospital	24 Ambulatory Surgical Center
25 Birthing Center	31 Skilled Nursing Facility
32 Nursing Facility	33 Custodial Care Facility
34 Hospice	41 Ambulance – Land
42 Ambulance – Air or Water	49 Independent Clinic
50 Federally Qualified Health Center	51 Inpatient Psychiatric Facility
52 Psychiatric Facility – Partial Hospitalization	53 Community Mental Health Center
54 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)	55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Facility	57 Non-Resident Substance Abuse Treatment Facility

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Place of Service Code List:			
61	Comprehensive Inpatient Rehabilitation Center	62	Comprehensive Outpatient Rehabilitation Center
65	End Stage Renal Disease Treatment Facility	71	State or Local Public Health Clinic
72	Rural Health Center	81	Independent Laboratory
		99	Other

Box 24C: EMG

- Situational
 - For services delivered during an emergency situation that typically require Prior Authorization, a “Y” must be entered in this box. Providers must maintain supporting documentation on file.
 - An appropriately entered “Y” submitted in this box will prevent a copay from being deducted for services subject to a copay.
 - Refer to Chapter I of the MaineCare Benefits Manual for a list of services exempt from copays: <http://www.maine.gov/sos/cec/rules/10/ch101.htm>.

Box 24D: Procedures, Service or Supplies

Figure 3-11: Box 24D, Procedures, Service, or Supplies

- Required
 - Enter the appropriate procedure code and modifier(s) in the unshaded area, if appropriate. Procedure codes and modifiers may be found in:
 - Chapter III of the MaineCare Benefits Manual and on the MaineCare Services website, <http://www.maine.gov/sos/cec/rules/10/ch101.htm>.
 - The CMS Healthcare Common Procedure Coding System (HCPCS) code adding the HCPCS code modifiers when appropriate.
 - When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line.
 - The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). The 11-digit NDC number is printed on the drug package in a 5-4-2 format. If the segments do not have the

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- appropriate number of digits, you will need to add zeros at the beginning of the segment.
- Report the NDC quantity in the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram), ML (milliliter) or ME (milligrams). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).
- All ingredients that make up a compound prescription must be identified on the claim and a unique HCPCS must be assigned to each ingredient. Each HCPCS must be entered as a separate line item. The associated units, NDC number, the NDC Drug Quantity, and the Composite unit of measure must also be reported.
- When entering NDC, only column D is used; all other columns are blank on that line.
- Modifiers
 - The Form CMS-1500 has the ability to capture up to four modifiers.
 - Use appropriate modifiers when billing for serious reportable events.
- CRNAs
 - CRNAs bill with the QZ modifier for a CRNA service, without medical direction by a physician and a QX for CRNA service with the medical direction by a physician.
- Repair/Replacement Procedures must be billed with the RA or RB modifiers as appropriate.
- Bi-lateral procedures require the code with the 50 modifier on one claim line.
 - Procedure is reimbursed at 150% of the allowed amount.
- Family Planning services must be billed using FP modifier.
 - Family planning services are those provided to prevent or delay pregnancy or to otherwise control family size. Counseling services, laboratory tests, medical procedures and pharmaceutical supplies and devices are covered if provided for family planning purposes.
- State Funded Abortion Services requires SE modifier on every line on the claim. Unrelated services should be billed on a separate claim.
- State Supplied Vaccines require the use of the SL modifier on the vaccine code only. SL modifier should not be appended on the administration code.
- Ambulance Providers:
 - Ambulance providers should insert the H9 modifier before the origin/destination code, when appropriate.
 - In the Modifier Box, enter the appropriate two letters for the transport's place of origin and destination from the following list:

Table 7: Transportation Origin/Destination Codes

Code	Description
D	Diagnostic or therapeutic site other than P or H
E	Residential domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site transfer (i.e. airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility

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Code	Description
N	Skilled Nursing Facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMP non-hospital facility, clinic, etc.)
QL	Patient pronounced dead after ambulance called
UC	Unclassified ambulance service

Box 24E: Diagnosis Pointer

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.
A.	B.	C.	D.							
E.	F.	G.	H.							
I.	J.	K.	L.							
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER		
From	To				CPT/HCPCS	MODIFIER				
MM	DD	YY	MM	DD	YY					
1										
2										
3										
4										
5										
6										

list only the line letter, not the ICD codes

Figure 3-12: Box 24E Diagnosis Pointer

- Required
 - From Box 21, enter the line letter or letters (A-L) that identify the relevant diagnosis code(s) for the service line.
 - List only the line letter(s).
 - Do not enter the codes themselves.
 - List up to 4 characters in the unshaded area.
 - Enter letters left justified. Do not use commas between the letters.

E.
DIAGNOSIS POINTER
ABCD

Figure 3-13: Diagnosis Pointer Example

Box 24F: Charges

- Required
 - Enter the usual charge for the service provided.

- For more information on charges, see the MaineCare Benefits Manual:
http://www.maine.gov/dhhs/oms/provider/provider_index.html.
- Must be in valid currency format: dd.cc, e.g., 24.00.
- Do not put a \$ sign before the total. The \$ can be picked up as an 8.

Box 24G: Days or Units

- Required
 - Enter the number of days of service or the units of supplies provided.
 - Do not use decimal points or fractions.
 - Units must be whole numbers.
 - Do not use ¼, ½, ¾, etc.
 - In cases where services provided include less than a whole unit of a service, the unit shall be rounded up only if equal to or greater than fifty percent (50%) of the unit of service, e.g. 1.5 units of service equals 2 units of service rounded up; 1.4 units of service equal 1 unit of service. The procedure code for the smallest unit of service must be used.
 - Specific provisions in any other Chapters or Sections of this Manual will supersede this rounding requirement.
 - Actual anesthesia time in minutes is reported in 24G.
 - To find the definition of a unit, refer to the code descriptions or maximum allowance column in Chapter III of the MaineCare Benefits Manual, or refer to the CPT and HCPCS standard code listings.

Box 24H: EPSDT Family Plan

- Required
 - Enter a “Y” if the service is EPSDT. Enter an “N” if the service is not EPSDT.
- Early Periodic Screening Diagnosis and Treatment is known as “Bright Futures” in Maine.

Box 24I: ID. Qual.

- Not Used
 - Form is precompleted with the word “NPI” in the non-shaded area of the line.

Box 24J: Rendering Provider ID #

- Situational (Required if Provider Type is listed below):
 - Enter the applicable NPI.
 - Providers billing for interpreter services need to put the healthcare provider’s rendering id on the claims.
 - A claim form may have only one (1) rendering NPI. The same rendering provider could bill multiple services on a single claim.

Table 8: Provider Types Requiring Renderings

Provider Types Requiring Renderings
Advanced Practice Registered Nurse Group
Audiology Group
Behavioral Health Clinicians Group
Chiropractic Group
Dental
Family Planning Agency

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Provider Types Requiring Renderings
Hospital Based Professionals
Indian Health Services Provider
Intermediate Educational Unit (for therapy services)
Mental Health Clinic/Behavioral Health Services, Community Support Services
Non-Hospital Affiliated Clinic
Occupational/Physical Therapy Group
Physicians Group
Psychiatric Hospital Professional Services
Podiatry Group
Public School (for therapy services)
School Health Center
Speech Language Pathology Group
Speech/Hearing Therapist Group
State Agency/Dentist Public Health
Substance Abuse Provider
Vision Services Provider Group

3.11 BOXES 25 through 33

25. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____				33. BILLING PROVIDER INFO & PH # () a. NPI b. _____					

Figure 3-14: Boxes 25 through 33

Box 25: Federal Tax I.D. Number

- Required
 - Enter the TAX ID number matching the Pay To NPI/API.
 - Enter an X to identify the number as a Social Security Number (SSN) or an Employer Identification Number (EIN).

Box 26: Patient's Account No.

- Required
 - Enter the provider internal patient number/identifier in this location. (Maximum length 38 but MaineCare will only return 20 characters on the remittance advice (RA) or 835).
 - Field may be alpha numeric
 - Examples:
 - 123456
 - Smith, John
 - Smit1234

Box 27: Accept Assignment

- Not Used

Box 28: Total Charge

- Required
 - Total the charges in Box 24, Column F, and enter the amount.
 - For multi-page claims, enter the total for all pages on the last page.
 - Claims with totals on each page will be considered as individual claims.
 - Must be in valid currency format, dd.cc, e.g., 24.00. Do not put a \$ sign before the total. The \$ can be picked up as an 8.

Box 29: Amount Paid

- Situational (Required when billing after insurance).
 - If billing after other insurance, attach an EOB.
 - Enter the insurance payment in this Box.
 - Must be in valid currency format, dd.cc, e.g., 24.00. Do not put a \$ sign before the total. The \$ can be picked up as an 8.

Box 30: Reserved for NUCC Use

- Not Used

Box 31: Signature of Physician or Supplier

- Required
 - Enter the signature of the provider of service or supplier, or his/her representative, and either the 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date the form was signed.
 - The signature may be typed or stamped.
 - Do not use “signature on file”.
 - Degree or credentials are not required.

Box 32: Service Facility Location Information

- Required
 - Enter the physical address of the facility where services are rendered (ex. Hospital or Nursing Home for a private practice physician).

Box 32a: Not Labeled

- Not Used

Box 32b: Service Location ID

- Situational (Required if provider has more than one service location, unless the service location and billing provider address are the same.)
- The service location ID is not needed if:
 - The provider has enrolled with only one service location within MaineCare.
 - The service location and the billing provider address are the same.
- Service Location ID: 10 Digit NPI or API plus the 3-digit servicing location identifier of -001, -002, etc. (i.e. 1234567890-003).

Box 33: Billing Provider Info & PH. # ID

- Required

- Enter the billing provider's Pay-To address and phone number that matches W-9 information on file with the State Controller's office.
 - All Pay To address changes must be made through AdvantageME.

Box 33a: NPI-Pay To

- Not labeled on the CMS1500.
- Situational (An entry must be included in either 33a or 33b).
 - Enter the 10-digit billing provider's National Provider Identifier (NPI).
 - Sometimes referred to as the "Pay-To" NPI.

Box 33b: API

- Not labeled on the CMS1500.
- Situational (An entry must be included in either 33a or 33b).
 - Enter the Providers Atypical Provider Number or API.

Appendix A. Billing as Secondary or Tertiary Payer

Appendix A contains summarized billing instructions for billing MaineCare as the secondary or tertiary payer after any other insurance coverage.

These instructions apply for any of the following:

- For paper claims.
- MaineCare does process claims after Medicare as part of the Coordination of Benefits Agreement (COBA) file transmitted from Medicare.
- Providers must bill any third party payer prior to billing MaineCare.
- Billing for services after Medicare and Medicare C plans.
- Billing secondary and tertiary claim after traditional insurance plans.

Complete the CMS 1500 claim form according to MaineCare requirements, along with the following:

- Box 24F: An amount not to exceed the provider's usual and customary charges to the general public
- Box 28: Enter the total charges.
 - This must equal the total of the individual line item charges in 24F.
- Box 29: Enter the amount paid by the insurance company/third party.
 - This amount must be entered on the claim form.

Additional Instruction:

- The third party EOB must be attached to the claim form.
- A provider cannot charge the member the copay.